



CANNON BUILDING
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STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION

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Board of Speech Pathologists, Audiologists and Hearing Aid Dispensers

CLINICAL FELLOWSHIP YEAR PLAN (CFY)

REQUIRED FOR LICENSURE

A Delaware temporary license must be in your possession prior to beginning your CFY.

A copy of the CFY plan should be retained by the clinical fellow and the clinical fellowship supervisor.

I. Clinical Fellow:

Name: _____

Address: _____
City State Zip

Telephone Number: 302 - _____ Email: _____

Social Security Number: _____ - _____ - _____

II. Supervisor: (In the case of multiple supervisors, attach additional form(s).)

Name: _____

Address: _____
City State Zip

Delaware License Number: _____

Social Security Number: _____ - _____ - _____

ASHA Certification Area: ☐ SLP ☐ AUD

III. Clinical Fellowship Setting:

Facility Name: _____

Address: _____
City State Zip

Phone #: _____

Anticipated Beginning CF Date ____/____/____

Anticipated Ending CF Date ____/____/____

Is this registration agreement for only a portion of clinical fellowship? ☐ Yes ☐ No

IV. Clinical Fellowship Professional Experience:

Indicate the length of the clinical fellowship experience and number of hours per week below.

☐ 36 weeks of full-time professional employment of at least 30 hours per week.

☐ 48 weeks of part-time professional employment of at least 25 hours per week.

At least 80% of the clinical fellowship week will be spent in direct client contact (assessment/diagnosis/evaluation, screening, habilitation/rehabilitation) and activities related to client management. ☐ Yes ☐ No

V. Clinical Fellowship Supervision:

☐ There will be at least 36 supervisory activities during the entire clinical fellowship, including 18 hours of on-site observation and 18 other monitoring activities. Clinical fellowship supervision will be divided equally among three segments. There will be at least 6 hours of on-site observation during each one-third segment of the clinical fellowship and at least one other monitoring activity per month.

VI. Supervisor's Agreement:

I agree to conduct one formal evaluation during each one-third segment of the clinical fellowship. I, the clinical fellowship supervisor, have read, discussed, and agreed upon all sections listed above. I have read the "Clinical Fellowship Supervisor's Responsibilities" (ASHA). I agree to approve/disapprove, sign, and submit proof of completion, either a copy of the ASHA Clinical Fellowship Report or a letter of verification, to the Board office at least 30 days in advance of the expiration of the temporary permit. I will fulfill this responsibility even if I am not able to approve the clinical fellowship experience.

Signature

Date

VII. Clinical Fellow's Agreement:

I, the clinical fellow, have read, discussed, and agreed upon all sections listed above. I have verified that my supervisor holds a current Delaware license in the area in which I am seeking certification. If it is later determined that this is not correct, I assume full responsibility for an invalid clinical fellowship experience. I have read and agree to abide by the Code of Ethics listed in the Board's rules and regulations.

Signature

Date